DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 04-29

2. STATE: MARYLAND

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
APRIL 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Amount, duration, and scope of medical and remedial care and services provided to the categorically needy.

7. FEDERAL BUDGET IMPACT
a. FFY 2004 $ ($790,616)
b. FFY 2005 $ ($1,639,155)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19 A&B Page 4
Attachment 4.19 A&B, Page 4A
Attachment 4.19 A&B, page 4A-1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19 A&B, page 4 (97-30
Attachment 4.19 A&B, page 4A (92-21)
Attachment 4.19 A&B, page 4A-1 (96-6)

10. SUBJECT OF AMENDMENT
Change in reimbursement methodology to non-psychiatric hospitals in the District of Columbia. The reimbursement methodology is updated to reflect the actual charity care and bad debt incurred by the hospitals. A refined comprehensive case-mix comparison tool is introduced to compare performance between Maryland and DC hospitals.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
Susan Tucker, Executive Director
Office of Health Services

12. SIGNATURE OF STATE AGENCY OFFICIAL
Nelson J. Sabatini

13. TYPED NAME
Nelson J. Sabatini

14. TITLE
Secretary, Department of Health and Mental Hygiene

15. DATE SUBMITTED
June 23, 2004

16. RETURN TO
Susan Tucker, Executive Director
DHMH - OHS
201 W. Preston St., Ste 124
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17 DATE RECEIVED: JUN 30 2004

18 DATE APPROVED: AUG - 3 2004

PLAN APPROVED - ONE COPY ATTACHED

19 EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2004

20 SIGNATURE OF REGIONAL OFFICIAL

21 TYPED NAME: Carmen Keller

22 TITLE: Deputy Director, CMSO

23 REMARKS

FORM CMS-1 79 (07/92)

Instructions on **Back**

(5) An out-of-State hospital Licensed special-rehabilitation, except a hospital located in the District of Columbia, shall be reimbursed the lesser of its charges: or (i) the amount reimbursable by the host state's Title XIX agency; (ii) if the host state Title XIX agency does not cover inpatient rehabilitation hospital services, the amount reimbursable by the Title XVIII intermediary; or if (i) or (ii) are not applicable, the rate of reimbursement will be determined in accordance with Medicare standards and principles for retrospective cost reimbursement.

(6) For each hospital not participating in the Title XVIII Program, the State will apply the standards and principles described in 42 CFR Part 482.

(7) Medicare standards and principles are modified to apply the limits established by the Secretary of Health and Human Services under 42 CFR 413.30.

(8) The State will provide for a system to assure that claims by providers for reimbursement for inpatient hospital services meet requirements.

(9) A hospital located in the District of Columbia shall be paid a percentage of charges based on the result of multiplying the following four factors, A-D.

A. Factor 1 is the report period cost-to-charge ratio. This factor, which is determined by an analysis of the hospital's most recent cost report performed by the Maryland Medical Assistance Program or its designee, establishes the cost-to-charge ratio for the hospital during the cost report period.

B. Factor 2 is the cost-to-charge projection ratio. This factor, which is determined by an analysis of the hospital's three most recent cost reports performed by the Maryland Medical Assistance Program or its designee, projects the cost-to-charge ratio from the cost report periods two years prior to the latest cost report to the prospective payment period. The annual rate of change is applied from the mid-point of the report period used to develop Factor 1 to the mid-point of the prospective payment period. To reflect the accelerating pace of cost-to-charge ratio decreases, Factor 2 shall not be greater than 1.000.

$$Factor2 = \left(\sqrt[c]{B/A}\right)^{d}$$

A = cost to charge ratio, date 1
B = cost to charge ratio, date 2
c = # of days between date 1 and date 2
d = # of days between date 2 and end of rate year

$$\left(\sqrt[730]{.5240/.6476}\right)^{365} = .8995$$

For example:
6/30/01 C-T-C is .6476
6/30/03 C-T-C is .5240
730 days between 6/30/01 and 6/30/03
Rate year-end is 6/30/04, or 365 days
between date 2 and rate year end

C. Factor 3 is the efficiency and economy adjustment. This factor represents the fraction of the hospital's costs which the MMAP finds to be efficiently and economically incurred. In making this finding, the MMAP compares the hospital's cost of providing care to program recipients classified into DRG/age categories with the costs of providing care to identically classified program recipients in Maryland hospitals. In order to recognize the possibility that the severity of illness within DRG/age categories may be greater for program recipients treated in D.C. hospitals than in Maryland hospitals, the MMAP will adjust cost differences for positive DRG/age adjusted length-of-stay (LOS) differences between the hospital and the Maryland LOS. For hospitals other than the National Rehabilitation Hospital, the MMAP shall give 80% credit for positive LOS differences because for DRGs other than 462 (Rehabilitation) the cost of longer stay days is approximately 30% of the cost of average days. For the National Rehabilitation Hospital, the MMAP shall give 100% credit for the positive LOS difference because in DRG 462 the cost of longer stay days equals the cost of an average day.

a) Starting in April 2004 the MMAP will phase in a transition to the use of the All Patient Refined-Diagnosis Related Groups (APRDRG's) to replace the DRG/age categories comparisons. The APRDRG's reflect four severity of illness levels evaluating multiple comorbidities, age, procedures and principle diagnosis. The APRDRG's will eliminate the need for age and length of stay adjustments.

b) The phase in period will occur over a three year period with 100% use of APRDRG's beginning July 2006.

Costs of D.C. hospitals used in the above comparison are adjusted to reflect labor market differences between D.C. hospitals and Maryland hospitals as a ratio, based upon adjusted information as supplied in Hospital Statistics issued by the American Hospital Association as applied to the percentage of D.C. hospital costs which are labor expenses, If cumulative information starting from 1989 as supplied in Hospital Statistics reveals that the:

(a) Cumulative D.C. labor costs increase per full time equivalent (FTE) is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is greater than the cumulative increase in Average Hourly Earnings, Hospital Workers (AHE) as reported by the Bureau of Labor Statistics, then the Program will use information as supplied in the 1990— 1991 edition of Hospital Statistics; or if,

(b) Cumulative D.C. labor cost increase per FTE is greater than the cumulative Maryland labor cost increase per FTE and the cumulative Maryland labor cost increase per FTE is less than the cumulative increase in AHE, then the 1989 data supplied in the 1990—1991 edition of Hospital Statistics will be adjusted to recognize the portion of the D.C. increase in labor cost per FTE which does not exceed the cumulative AHE; or if

(c) Cumulative D.C. labor cost increase per FTE is less than the cumulative Maryland labor cost increase per Fit in any edition of Hospital Statistics, then the labor market difference shall be measured using that current issue of Hospital Statistics.

D. Factor 4 is the disproportionate share adjustor. An adjustment for approved disproportionate share hospitals as determined by the D.C. Title XIX Single State Agency shall be applied. The disproportionate share adjustor shall be the lesser of:

(a) the DSP adjustment factor as determined by the D.C. Title XIX Single State Agency; or

(b) the minimum payment amount required by federal law. For example, if the D.C. Medicaid DSP for a hospital is 2.3% factor 4 under this methodology will be 1.023.

(c) Starting in April 2004 the MMAP will phase in a transition to the use of the hospitals' uncompensated care ratio (UCC), consisting of charity care and bad debt, to replace the D.C. Medicaid DSP. For acute children's hospitals, the MMAP will adjust this factor to reflect the ratio of utilization of services provided to children in the MMAP HealthChoice Program versus the services provided to fee-for-service recipients.

(d) The phase in period will occur over a three-year period with 100% use of UCC beginning July 2006.

E. In no case shall the MMAP pay more than charges. Thus, the percent of charges paid shall not be greater than 1.000.

F. Payment for administrative days will be according to: (a) a projected average Medicaid nursing home payment rate; or (b) if the hospital has a unit which is a skilled nursing facility, a rate which is the lesser of that described in (a), or the allowable costs in effect under Medicare for extended services provided to patients of the unit.

10. Payment for administrative days, for recipients awaiting discharge from a psychiatric hospital to a residential treatment center will be according to the average Medicaid residential treatment center payment rate.

11. The Department reimburses a residential treatment center the lesser of, the provider's usual and customary charge, the provider's per diem costs for covered services established in accordance with Medicare principles of reasonable costs reimbursement as described in 42 CFR 413, or $300 per day. The $300 per day will be up-dated annually by the Centers for Medicare and Medicaid Service's published federal fiscal year market basket increase percentage relating to hospitals excluded from the prospective payment system.